Development on an Integrated System for Reporting, Analyzing and Learning from Adverse Incidents Involving Patients, Staff and Others.

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4-PTS Hotline - What is it?

An integrated and automated system that is easy to use for reporting, analyzing and managing incidents and near misses related to patient safety.

- Fosters “no blame” culture that encourages reporting of incidents and near misses
- Enables real time reporting and follow up of incidents through increase automation via a customized Incident Reporting System
- Improved access to data trends

Features

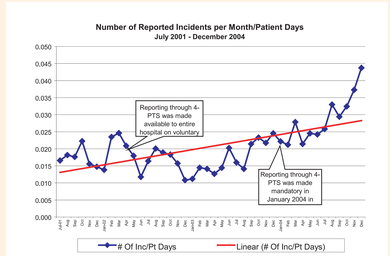
- Provides all employees and medical staff with the ability to report incidents, near misses, or patient safety issues in real time by telephone
- Permits reporting anonymously
- Within 24-48 hours, provides managers with information related to the adverse or potentially adverse event electronically
- Alerts Risk Management and Vice President of Quality of incidents that require reporting to an external body
- Codes the severity of the incident
- Categorizes incidents according to predefined areas of concern enabling an analysis of the trends and practices
- Allows results of investigation to be entered electronically
- Generates reports for Division, Units and Committees
- Reports are generated from the database and distributed to department managers and vice-presidents on a monthly basis
- Managers required to submit action plan for indicators not meeting pre-defined thresholds to VP Quality

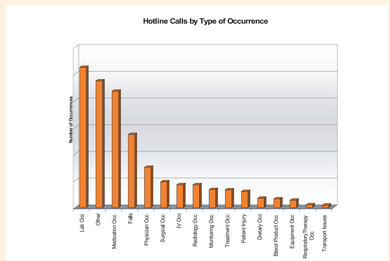
Process

- Incident or near miss discovered
- Employee notifies supervisor of incident
- Person who discovers incident calls 4-PTS hotline with
  - Patient name, location, event, date/time, description of event
- Data Analyst transcribes incident from Hotline to electronic database and responsible manager assigned to follow up
- Incident sent electronically to responsible manager, Risk Manager, VP Quality and others as necessary
- Responsible manager conducts investigation
- Findings of investigation are documented electronically onto the automated incident report
- Report with findings is sent back electronically to the Data Analyst, Risk Manager, VP Quality and others as necessary
- Data Analyst reviews findings and, if approves, finalizes and closes report
- If investigation is found to be incomplete, the report is sent back to responsible manager requesting additional information

Expected Outcomes

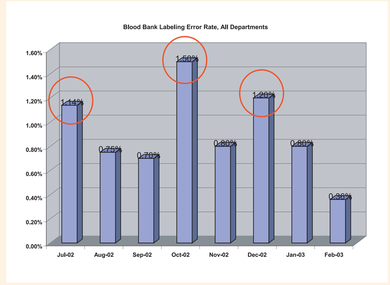
- Increased reporting rate for adverse events
- Increased individual awareness of patient safety
- Establish and maintain a patient safety culture
- Provide a mechanism for identifying trends
- Establish a mechanism for reporting patient safety related events using an electronic database





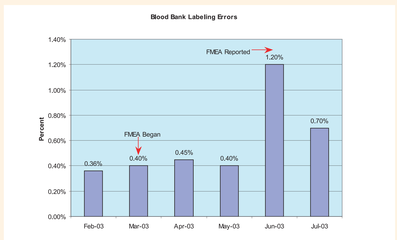
Laboratory Related Focus Areas

- Specimen lableing errors (271/525 occurrences)
- Delays in laboratory testing (tat issues)
- Incorrect laboratory procedure
- Laboratory procedure not performed
- Result delayed or not reported
- Technique problems such as drawing from above an IV, pouring from one collection tube to another
- Incorrect collection time
- QNS issues
- Issues related to the reporting of critical values



FMEA

- Improved orientation and training
- Developed rate based method to quantify blood bank errors



Blood Sample Labeling Errors

Failure Modes and Effects Analysis
June 2003

Reasons for Project

- AAMC Lab has identified the receipt of mislabeled specimens in the blood bank and core lab
- This mislabeling gives rise to the potential for grave harm to our patients

Problem Identification

- Blood specimens are being received in the laboratory with various type of patient identifiers on the tubes
- Blood specimens are being received in the laboratory with inaccurate patient information on the tubes

Project Goals

- Have a system in place by September 1, 2003 which will significantly reduce, if not eliminate the number of blood specimen labeling errors
- Assumption: The team can draw on the expertise of other members of the institution in defining the problems and researching the solutions

Review of Process

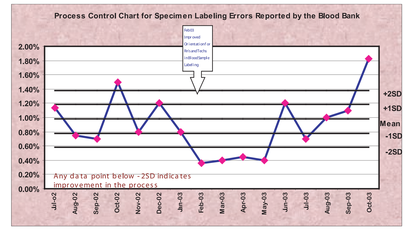
- Blood Specimen Ordering
- Laboratory
- Obtaining Blood Specimen
- Tracking Outcomes

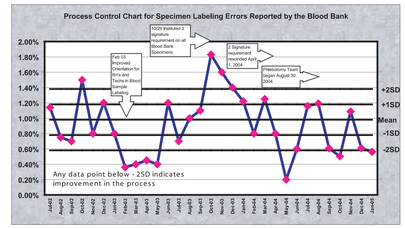
Tracking Outcomes

- Labeling errors are reported
- Establish rate-based measurement
- Tracking Outcome using Process Control Chart

FMEA Recommendations, June 2003

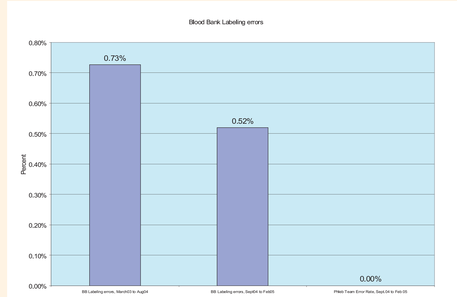
1. Lab order tracking was reconfigured to reduce wait time
2. Patient name and font size increased on laboratory label
3. Blank label added to separate patient labels on printer
4. Nursing policy for obtaining specimen changed to be consistent with laboratory policy
5. Procedure for drawing lab specimens stressed during orientation and staff recredentialing
6. Visual aids for drawing and labeling blood specimens placed on nursing areas
7. Re-education of staff for proper blood collection

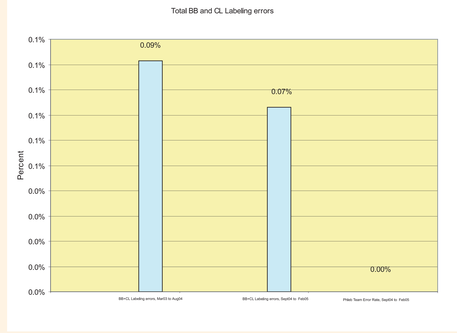




FMEA Re-convened October 2003 with additional recommendations:

1. Use patient account number as first patient identifier and the name as the second identifier
2. Establish a hospital wide phlebotomy team





Next Steps

- Retraining of non-phlebotomy team nursing staff on proper procedure for patient identification – double identifier
- Expand limited phlebotomy team to 24/7 hospital-wide with a goal of zero labeling errors
- Track department specific error rate
- Emphasize reporting of patient safety issues using the 4PTS Hotline procedure.